Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Hermann Health System

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-13-3323-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 16, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Hospital did not receive these refund requests or learn of this potential coverage until after the deadline for filing claims expired for each particular claim."

Amount in Dispute: $25,989.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual declines to issue payment for two reasons. First no preauthorization was sought or obtained from Texas Mutual. Second, the billing was untimely consistent with Rule 133.20. Notwithstanding the requestor's allegations, the requestor has not produced any evidence of when it was notified by Aetna. Further, the same Rule above also requires at (b) that "…A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted…" This the requestor did not do with its billing to Texas Mutual for all the disputed dates. Nor has the requestor produced that billing with its DWC-60 packet. The bill was untimely. The bill is still untimely. No payment is due. "

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 16 -29-2012 August 4 -6, 2012 December 20, 2012	Inpatient Hospital Services Inpatient Hospital Services Outpatient Hospital Services	$25,989.42	$12,208.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by a health care provider.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.

4. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
5. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services provided in an acute care hospital.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Dates of Service August 16 - 20, 2012

   Explanation of benefits dated April 8, 2013
   - 197 – Precertification/authorization/notification absent
   - 29 – The time limit for filing has expired

   Explanation of benefits dated July 11, 2013
   - 193 – Original payment decision is being maintained.

   Dates of Service December 4 – 6, 2012

   Explanation of benefits dated May 16, 2013
   - 29 – the time limit for filing has expired

   Explanation of benefits dated June 28, 2013
   - 193 – Original payment decision is being maintained

   Date of Service December 20, 2012

   Explanation of benefits dated June 3, 2013
   - 29 - The time limit for filing has expired

   Explanation of benefits dated July 18, 2013
   - 193 – Original payment decision is being maintained

Issues

1. Did the requestor support timely claim submission to Worker's Compensation Carrier once notification was made?
2. What is the applicable rule pertaining to reimbursement for inpatient services?
3. What is the applicable rule pertaining to reimbursement for outpatient services?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(a) states in pertinent part, "The health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section. (b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied." Review of the submitted documentation finds the following;
   a. UB04 with creation date September 26, 2012 for dates of service August 16, 2012 through August 20, 2012. Payer name is identified as "Aetna".
   b. UB04 with creation date December 11, 2012 for dates of service December 4, 2012 through December 6, 2012. Payer name is identified as "Aetna".
   c. UB04 with creation date January 24, 2013 for dates of service December 20, 2012. Payer name is identified as "Aetna".
   d. Document dated April 17, 2013 from The Rawlings Company LLC that states, "…Our records indicate that the workers' compensation carrier is responsible for the treatment provided by your organization…"
   e. First adjudication explanation of benefits dated April 8, 2013 for dates of service, August 16 – 20, 2012
   f. First adjudication explanation of benefits dated May 16, 2013 for dates of service, December

4 – 6, 2012

g. First adjudication explanation of benefits dated June 3, 2013 for date of service, December 20, 2012.

The Carrier denied all the disputed services as, 29 – "The time limit for filing has expired." The Division has finds;

i. The filing deadline exception detailed in Rule 133.20 (b), does not apply to date of service August 16 – 20, 2012 as the submitted "proof of timely filing", (notice dated April 17, 2013 from The Rawlings Company), is after the explanation of benefits (April 8, 2013). Requestor did provide copy of UB04 for this date of service with creation date of 02/25/13. However, evidence that this claim was submitted within 95 days of notification of the correct worker's compensation carrier was not found. The Carrier's denial is supported for this date of service.

ii. The filing deadline exception detailed in Rule 133.20 (b), does apply to dates of service December 4 – 6, 2012 and dates of service December 20, 2012 as the "proof of timely filing" that the disputed services was filed to the correct worker's compensation carrier within 95 days of notification is supported by the dates of the original explanation of benefits from the carrier and copies of claims submitted to Texas Mutual. These dates of services will be reviewed per applicable rules and fee guidelines.

2. For dates of service December 4 – 6, 2012. 28 Texas Administrative Code §134.401(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 143 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent. (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

   28 Texas Administrative Code §134.401§134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation found supports that the DRG assigned to the services in dispute is DRG 256, and that the services were provided at Memorial Hermann Memorial City.

   Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $9,579.20. This amount multiplied by 143% results in a MAR of $13,698.26. The requestor is seeking $11,973.20. This amount is recommended.

3. For dates of service December 20, 2012. 28 Texas Administrative Code §134.403 (f) states. "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied. (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."

   Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 97760 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated

therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 25% of the practice expense. This procedure does not have the highest practice expense for this date. The reduced rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2012 is $36.86. This amount multiplied by 2 units is $63.48. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of $102.31

- Procedure code 97003 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 25% of the practice expense. This procedure has the highest practice expense for this date. The rate listed for this code in the Multiple Procedure Payment Reduction Rate File for 2012 is $82.69. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of $133.28.
- The total allowable reimbursement for the services in dispute is $235.59. This amount is recommended.

4. The total recommended payment for the services in dispute is ($11,973.20 +$235.59) = $12,208.79. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $12,208.79. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $12,208.79.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $12,208.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		March 12, 2015
Signature	Medical Fee Dispute Resolution Officer	Date
		March 12, 2015
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.